Arkansas Pharmacy Permit Application

Completion of this application form is necessary for consideration for a permit to operate as an out of state pharmacy pursuant to Arkansas Pharmacy Law and Regulation. (You may download statutes and regulations from our website. The web address is: http://www.arkansas.gov/asbp/) Disclosure of this information is voluntary. However, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application. All candidates for licensure, renewal, and/or examination have an obligation to update and supplement the information and responses on this application if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be accurate. Please note that the information provided on this application is subject to the public information laws of this jurisdiction.

Carefully follow the directions on this application form. In addition, note the following:

1. Type or print legibly with black or blue ink only.
2. The registration and application fees are NOT refundable.
3. Please complete the entire application and submit additional pages as needed or as indicated in the instructions.
4. Arkansas pharmacies are licensed for two year periods as follows: 2004-2005, 2006-2007, 2008-2009, etc. If you expect your application to be completed in an even-numbered year (including the initial inspection required for new pharmacies,) the fee is $450.00;if it will be complete in an odd-numbered year, the fee is $300.00. If you have any questions about the fees or the application, please do not hesitate to contact us.
5. If this application is made as the result of a change in ownership of a currently licensed Arkansas business, the fee is $150.00.

Supporting Documentation and Fees

Submit the following documents and fees:

1. This completed application (6 pages.)
2. The application fee for an Arkansas state pharmacy. (See item 4 above.)
3. Supplemental information as specified in the application.
4. An 8.5 by 11 inch copy of your floor plan, and description of your facility, if it is not a retail pharmacy.
5. A copy of your lease if the facility is in leased space.

Your application is NOT considered complete until all supporting documents and fees have been received by the Arkansas State Board of Pharmacy.

FOR OFFICE USE ONLY

License # _____

Date Issued: _____

Fee Submitted: _____

Application for a Permit to Operate as an *Arkansas Pharmacy*

PART I: GENERAL INFORMATION					
1.	*Business Name*				
	dba				
2.	*Physical Address*				
	Street				
	City				
	State		*Zip*		
3.	*Mailing Address*				
	Street or PO Box				
	City				
	State		*Zip*		
	Telephone Number		*Fax Number*		
	Website				
4.	*Type of Pharmacy (check all that apply)*	___ Full line retail pharmacy ___ Internet pharmacy * ___ Clinic* ___ Chain ___ Independent		___ Nuclear ___ Specialty pharmacy* ___ Mail Order* ___ Other* *(please explain on separate sheet)*	
5.	*Person with whom the Arkansas State Board of Pharmacy may communicate regarding this application:*				
	Name				
	Telephone		*Cell Phone*		
	Email				
6.	*Is this a change of Ownership? If yes, who was the previous owner?* _____			Yes [ ] No [ ]	
7.	Is the pharmacy located in a building owned by the pharmacy owners? If you answered "no" please attach a copy of the lease.			Yes [ ] No [ ]	
8.	*Hours of Operation*				
		Please express in terms of a.m. and p.m.		*Total Hours/Day*	
	Sunday				
	Monday				
	Tuesday				
	Wednesday				
	Thursday				
	Friday				
	Saturday				
			Total Hours per Week		
9.	*Federal DEA Permit Number*				
10.	*Name of DEA Registrant*				
11.	*Please list the states in which the applicant is licensed or write"none" if the applicant is not licensed in any other state. You may attach another sheet if you need more space.*				

PART II: APPLICANT HISTORY

Please answer each of the following questions by putting a check (√) in the appropriate box on the right. You must answer each question with a "Yes" or "No" response as no other response is acceptable. All "Yes" answers MUST be explained in detail in a separate SIGNED and NOTARIZED affidavit. The affidavit should include all relevant dates, and identify the relevant jurisdiction and/or entity involved. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action. NOTE: If you answer "Yes" to any of the questions below and you have already submitted a detailed affidavit to the Arkansas State Board of Pharmacy explaining your response you need not submit another detailed affidavit. Please note the date of your previous submission next to the applicable question(s).

11.	*Is their any disciplinary action pending against the pharmacy(applicant) by any licensing jurisdiction, the USDA, Drug Enforcement Agency, or any state drug enforcement authority? If yes, please explain on a separate sheet.*	Yes [ ] No [ ]
12.	*Have any of the applicant owners, officers, directors, or stockholders ever been convicted of a felony or crime involving the practice of pharmacy? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	Yes [ ] No [ ]
13.	*Has any sanction or disciplinary action been taken regarding any license, permit or registration issued to the applicant, officers, directors, partners or stockholders involving the practice of pharmacy? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	Yes [ ] No [ ]
14.	*Are there any charges pending against the applicant, officers, directors, partners or stockholders involving the practice of pharmacy? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	Yes [ ] No [ ]
15.	*Has the applicant ever had any application for a license or permit refused or denied by any licensing authority? If yes, please explain on a separate sheet.*	Yes [ ] No [ ]
13.	*Has the applicant ever been the subject of disciplinary action or been sanctioned by any licensing authority? If yes, please explain on a separate sheet.*	Yes [ ] No [ ]
14.	*Has the applicant ever had a registration issued by a controlled substance authority revoked, suspended, surrendered, limited, or restricted? If yes, please explain on a separate sheet.*	Yes [ ] No [ ]

PART III: PERSONNEL

16. *List all individuals filling prescriptions or performing any function considered to be the practice of pharmacy for this business. You may attach additional sheets if needed.* ***YOU MUST NAME A PHARMACIST IN CHARGE.***

Name	License #	Hours/Wk	Age	Degree	Hire Date
Pharmacist in charge					
Other pharmacists					
(Continued on next page.)					

Interns	License #	Hours/Wk	Hire Date
Pharmacy Technicians	**Registration #**		**Hire Date**

PART IV: BUSINESS OWNERSHIP

17. Business Name:_____

Select the appropriate form of ownership from the choices below.

[ ] *Sole Proprietorship- Please provide the name and address of the owner.*

_____

_____

_____

[ ] *Partnership Name:*

General Partnership – *please provide the names and addresses of all partners. You may attach a list of partners if there is not enough space.*

_____

_____

_____

_____

Limited Partnership – *please provide the names and addresses of all partners and indicate if they are general partners or limited partners. You may attach a list of partners if there is not enough space.*

_____

_____

_____

_____

[ ] *Corporation Name:*

[ ] Check if Subchapter S Corporation

Employer Identification Number: _____

State of Incorporation _____

Is this corporation publicly traded? [ ] Yes [ ] No

Is this corporation a subsidiary of another company or corporation? [ ] Yes [ ] No

If yes, please explain your relationship to your parent company on a separate sheet or provide a schematic which illustrates the relationship.

President _____

Vice President _____

Secretary _____

Treasurer _____

Director _____

If you need additional space for the corporate officer list, please attach the list as a separate document.

[ ] *LLC Name:*_____

You may be contacted for additional information.

Officers

President _____

Vice President _____

Secretary _____

Treasurer _____

If you need additional space for the corporate officer list, please attach the list as a separate document.

Name(s) of individual(s) who own more than twenty percent (20%) of the stock or voting rights of the company.

_____

_____

_____

[ ] *LLP Name:* _____

You may be contacted for additional information.

Please provide a general description of your company organization.

_____

_____

_____

Please provide the names and addresses of all partners. You may attach a list of parnters if there is not enough space.

_____

_____

_____

_____

PART V: OPERATIONS

18. Please respond to the following statements/questions on the bottom of this sheet and the back of it. You can attach a separate sheet if you need more space to respond, or if you wish to use a computer to record and print your responses.

(A) Describe in detail how the pharmacy will comply with regulation 09-00-0001 – patient counseling, patient profile, drug use evaluation.
(B) Describe in detail how the pharmacy will ensure patient freedom of choice of providers.
(C) How will your pharmacy and the pharmacist in charge ensure that patient confidentiality is maintained?
(D) Describe the computer hardware and software that will be used in the pharmacy.
(E) How does your pharmacy ensure a valid patient/physician relationship?

PART VI: LICENSURE

Attach copies of the following documents to this application:

(A) *A copy of the floor plan of the pharmacy showing the entrances and how it relates to other businesses in the building if it is not a free-standing building.*

(B) *A copy of your lease if you do not own the facility.*

PART VII: APPLICATION FEE *Check one of the following.*

[ ] This is a new business.
What is the date this application will be submitted to the Arkansas State Board of Pharmacy? Add thirty days. What is the new date?_____
If this date falls in an even numbered year, the fee is $450.00
If this date falls in an odd-numbered year, the fee is $300.00

[ ] This is a change of ownership of a current license holder.
The fee for a change of ownership is $150.00.

PART VIII: CERTIFICATION *Please read carefully and sign below.*

I swear, or affirm that all statements made herein and on the attached forms are true and correct. All of the provisions of Arkansas laws and regulations related to the practice of pharmacy in Arkansas will be faithfully observed during the period any permit issued may be in force and effect.

I swear and affirm that I know where to locate the statutes and regulations related to the practice of pharmacy in Arkansas. (They are available online at the Arkansas State Board of Pharmacy website in the Pharmacy Lawbook section under the Pharmacy Practice Act § 17-92-101 *et seq* and Regulations 1 through 12.)

By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form, that I have personally completed this form, that the information given in this application is true, correct and complete to the best of my knowledge. I authorize the Arkansas State Board of Pharmacy to review files pertaining to this application and related documents, and all law enforcement records, administrative records, and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization for entities in possession of applicable information to release such information to the Arkansas State Board of Pharmacy.

Signature of Owners/Representative: _____

Print the name of the Owner/Representative: _____

Position :_____ Date:_____

Signature of Pharmacist in Charge:_____

Print the name of the Pharmacist in Charge: _____

Position :_____ Date:_____

Checks should be made payable to: *Arkansas State Board of Pharmacy.*

Return the completed application and all related documents and fees to: Arkansas State Board of Pharmacy, 101 East Capitol, Suite 218, Little Rock, AR 72201; Telephone: 501-682-0190
Website: *http://www.arkansas.gov/asbp*